STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155165	A. BUILDING 00 B. WING	12/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW VILLAGE	586 EASTERN BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for Recertification and State Licensure Survey. This was in conjunction with the Investigation of Complaint #IN00121184. Survey dates: December 11, 12, 13, 14, 17 and 18, 2012 Facility number: 000082 Provider number: 155165 AIM number: 100289640 Survey Team: Jill Ross, RN, TC Diana Sidell, RN Gloria Reisert, MSW Census bed type: SNF/NF: 108 Total: 108 Census payor type: Medicare: 19 Medicaid: 69 Other: 20 Total: 108 Supplemental sample: 1 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law.Please accept this plan of correction as our credible allegation of compliance. Please find enclosed the plan of correction for the survey ending **December 18, 2012.** Due to the low scope and severity of the survey finding, please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. THe facility additionally requests paper review IDR for F329. Should additional information be necessary to confirm said compliance, feel free to contact me.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	Quality Review completed on January 3, 2013 by Cheryl Fielden RN.			

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F0156 SS=A	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the			

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	individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to ensure a resident was issued "Notice of Termination" when therapy was completed and Medicare benefits were stopped. This deficient practice affected 1 of 3 residents reviewed for Medicare Liability and Appeal Notices. (Resident #2) Finding includes: On 12/18/12 at 2:45 p.m.., a request was made to the Business Office Manager to view the Medicare Liability and Appeal Notices issued to Resident #2 when she was discharged to home after completing therapy. During an interview at that time, the Business Office Manager indicated " She went home. That was	F0156	F156 States that the facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the	01/19/2013

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	a time when we didn't know we were supposed to be issuing the letters to everyone. Since she went home and didn't exhausted her benefits, we didn't get a letter signed before she left." 3.1-4(l)(1)		State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.The facility must furnish a written description of legal rights which includes:A description of the manner of protecting personal funds, under paragraph (c) of this section;A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to	

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			Medicaid eligibility levels.A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.The facility must prominently display in the facility written	

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			information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. The facility will ensure this requirement is met through the following corrective measures:1. Resident #2 was issued the Notice of Medicare Non-Coverage.2. All Medicare residents have the potential to be affected. All Medicare residents will be audited by the Administrator or designee to ensure that all required Notice of Medicare Non-Coverage Notices has been issued as appropriate. 3. Any resident who is on Medicare, who is either discharging from the facility or being removed from Medicare Services, will be issued the Notice of Medicare Non-Coverage within 48 hours of the discharge/removal from benefits. The Administrator or designee will monitor all Medicare residents who are either discharging home or who are being removed from Medicare benefits to ensure that the appropriate Notice of Medicare Non-Coverage Notice is serviced within 48 hours. In the event that a resident discharges unexpectedly, before the notice can be issued, then the notice will attempt to be issued via certified	

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			mail.Business Office Staff will be in-serviced on or before January 17 th by the Administrator (see Attachment 156-3) on the Check List for Issuing a Notice of Medicare Non-Coverage Notice (see Attachment 156-1). 4. The Business Office Manager or designee will utilize the Continuous Quality Improvement Notice of Medicare Non-Coverage Letter tool (see Attachment 156-2) to ensure that all Medicare residents receive the appropriate notice of non-coverage letter as appropriate weekly for 4 weeks, then monthly for 6 months, then quarterly thereafter. These audits will be reviewed during the facility's quarterly CQI meetings and the plan of action adjusted accordingly. If a threshold of 95% is not met, the plan of action will be adjusted accordingly by the CQI committee. 5. The above corrective measures will be completed on or before January 17 th , 2013.	

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview the facility failed to notify the physician and the family when there was a significant change of Resident	F0157	F157 Requires that a facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested	01/19/2013

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	#108's condition. This affected 1 out of 6 residents reviewed for accidents and hospitalizations. Findings include: Record review for Resident #108 was done on 12/13/12 at 3:05 p.m. This resident was admitted on 8/3/12 and then readmitted on 9/27/12 after she had been hospitalized on 9/24/12. Her diagnoses included but were not limited to: esophageal reflux, anxiety, chronic obstructive lung disease (COPD), anemia, and depression. Progress notes were received 12/17/12 at 2:40 p.m., from the Medical Records Designee. This resident was seen on 9/17/12 by psychiatric services. A note dated 9/19/12 stated, "Resident remains very disorientated..." There were no previous notes of this resident being disoriented. On 9/20/12 a note stated, "...Resident was noted twice during this shift to enter another resident's room without permission..." On 9/21/12 the note indicated no signs or symptoms of confusion at 2:06 a.m. At 3:12 p.m., on 9/21/12 the note stated, "Is still confused today..." At 10:30 p.m. on 9/21/12 the note stated, "...Resident continues to be confused and rambles		family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.The facility will ensure this requirement is met through the following corrective measures:1. Resident #108 current condition has been reviewed by and IDT team and communicated to physician and family.2. All	

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	incoherently." On 9/22/12 at 2:49 a.m., the note indicated resident continued to be confused. On 9/22/12 at 12:55 p.m., the note stated, "Resident remains confused at most xs (times) and lethargic this shift. On 9/23/12 at 12:01 p.m., the note stated, "...Confusion noted..." On 9/24/12 at 12:12 p.m. the note indicated resident had been "more disorientated". A note on 9/24/12 at 4:55 p.m. stated, "Resident confused with paranoia noted. Pushing wheelchair around nursing without O 2 on...Mini neb (breathing treatment) given with O 2 saturation up to 90%..." They received an order to send the resident to the hospital and family was notified at this time. In reviewing the record there was no notification made to the physician of the change in her condition with the confusion until 9/24/12 at 4:55 p.m., when there had been confusion for many days prior to this one. Review of the care plan dated 8/16/12 on 12/17/12 at 10:40 a.m., from Medical Records Designee, stated, "...resident also has respiratory problems which could be a contributing factor to cognitive ability		residents with a recent change in condition have the potential to be affected. Any resident with a recent significant change in condition will be audited, by DNS or Designee, to ensure that the physician and family have been notified. 3. The charge nurse who identifies the change in condition will contact the resident's physician and family to communicate the change. The charge nurse will document the nurses' actions/interventions in the nurses' notes and will add to the daily charting. The DNS, or designee, will review documentation to ensure physician and family are notified . If family and physician are not notified, appropriate action will be taken. Nursing will be in-serviced on Resident Change of Condition Policy and Procedure by the DNS and Staff Development Coordinator on or before January 17 th , 2013 (see Attachment A). 4. The DNS or designee will utilize the Continuous Quality Improvement Change of Condition tool (see Attachment 157-1) to ensure that physicians, family, and responsible party are notified timely about changes in resident's condition. The Continuous Quality Improvement Change of Condition tool will be utilized to ensure compliance is being met weekly for 4 weeks, then monthly for 6 months, then quarterly thereafter. These audits will be reviewed during the	

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	at times..." Interview with the Medical Records Designee on 12/17/12 at 10:40 a.m., she indicated this resident did not keep her oxygen on as directed and there had been times when her oxygen levels went down. Interview with the Unit Manager for 2nd floor on 12/17/12 at 11:00 a.m., she indicated this resident was doing much better now that she keeps her oxygen on better. There should always be notification to the doctor of a change in condition. 3.1-5(a)(2)		facility's quarterly CQI meetings. . If a threshold of 95% is not met, the plan of action will be adjusted accordingly by the CQI committee. 5. The above corrective measures will be completed on or before January 17 th , 2013.	

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F0250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to provide medically related social services to a resident when the discharge plan changed from going home after rehabilitation to needing to remain in the nursing home for long term care due to non-compliance with therapy (Resident #81), and failed to assist a resident in obtaining services upon discharge (Resident #159). This deficient practice affected 2 of 2 residents who were reviewed for social services for discharge planning. Findings include: 1. Review of the clinical record for Resident #159 on 12/17/12 at 10:09 a.m. indicated the resident was admitted on 9/21/12 and had diagnoses which included, but were not limited to: Chronic airway obstruction - chronic with exacerbation; bipolar disorder, agoraphobia with panic disorder; post traumatic stress disorder, anxiety state, chronic pain, schizophrenia	F0250	F250 States that the facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.The facility will ensure this requirement is met through the following corrective measures:1. Resident #81 care plan was updated to reflect the resident's extended stay in the facility. Resident # 159 care plan was updated to address the resident's discharge goals and needs. Resident #159 has since discharged home. 2. All residents who have the goal to discharge home have the potential to be affected. All resident's that have a goal to discharge home will be audited, by the DNS or designee, to ensure appropriate care plans and interventions are in place. Additionally, all residents who admitted with the goal to discharge home but are staying in the facility for an extended period of time, will be audited by DNS or designee to assure care plans have been updated .3. Social Services Director will complete the Discharge to Home Check List (see Attachment 250-1). The	01/19/2013

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	A Social Service note dated 9/26/12 at 2:30 p.m. indicated: "...Resident plans to live with [name of family member] upon d/c from facility..." Review of the 9/28/12 Admission MDS [Minimum Data Set] Assessment:" Resident expects to be discharged to the community". The 9/28/12 Admission MDS Assessment also indicated the resident scored a 15 with good recall and orientation and the resident was alert and oriented x 4 per nursing notes. On 10/8/12, [name of agency] evaluator visited the resident where she also indicated to him that she was planning on only a short term stay for rehab and would discharging to home to live with family. A Social Service note dated 11/1/12 at 2:27 p.m. indicated - "spoke with resident at length regarding some concerns she is experiencing. She stated that she wanted to d/c [discharge] to [name of facilities]. She is currently under the care of therapist [name of agency]. The resident requested that I speak with her therapist about her d/c plans and any other concerns...Res [Resident] has an apartment that is in her name, but		IDT will review the form to ensure all arrangements are met. Any resident who is designated to discharge to home and, it is identified that they are unable to do so, the care plan will be updated by the IDT to ensure proper plans are in place. Social Services will be in-serviced on Resident Discharge to Home Policy by the DNS and Administrator on or before January 17 th , 2013 (see Attachment 250-2). 4. Social Services will utilize the Discharge to Home checklist (see Attachment 250-1) to ensure that all appropriate services have been arranged for residents who are discharging home. Additionally, the Social Services Director or designee will utilize the Continuous Quality Improvement Discharge Planning/Discharge to Home tool (see Attachment 250-3) to ensure residents' discharge plans and services are appropriate weekly for 4 weeks, then monthly for 6 months, then quarterly thereafter. These audits will be reviewed during the facility's quarterly CQI meetings and the plan of action adjusted accordingly. These audits will be reviewed during the facility's quarterly CQI meetings. If a threshold of 95% is not met, the plan of action will be adjusted accordingly by the CQI committee. 5. The above corrective measures will be completed on or before January	

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	155165	A. BUILDING 00 B. WING	12/18/2012

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	[name of person] was living there now. She does not want to go back to the apt for reasons of it having mold issues....Will f/u [follow up] with resident for encouragement, motivation and any new or existing concerns or problems." Review of an 11/21/12 Notice of Medicaid Reimbursement indicated the resident would no longer be covered after 12/21/12. An 11/27/12 Nurse Practitioner note indicated the resident stated to her that she completed rehab and wants to be home soon. A Social Service note dated 11/27/12 at 3:17 p.m., indicated - "Res came to writer to discuss d/c plans. She stated that she wants to leave the facility in a couple of weeks and has secured an assisted living apartment. Writer assured resident that all d/c planning would be coordinated before her departure. Will continue to f/u[follow up] with d/c planning prn [as needed]." No further notes could be located. During an interview with the resident on 12/12/12 at 10:00 a.m., she indicated she was going to be discharged from the facility on		17 th , 2013.	

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	12/21/12. A second interview with the resident on 12/17/12 at 1:30 p.m., indicated she was planning on going to a new apartment situation on 12/20/12 and that all arrangements and consents had been developed and set-up by the facility Social Worker, MD and a case worker from an outside agency. During an interview with Social Worker #1 on 12/17/12 at 1:35 p.m., she indicated she knew the resident was going home around the 22nd of December, but the resident set up her own services. She indicated she should have documented what the plans were after talking to the resident to see if there was anything else she could do for the resident. At 3:30 p.m., Social Worker #1 indicated that the resident was very confused today and did not know what she was talking about as the information she gave was inaccurate because the resident was going back home since the mold problem was taken care of and she was actually on a waiting list for the apartments she wants. 2. Review of the clinical record for Resident #81 on 12/13/12 at 4:31			

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	p.m., indicated the resident was admitted to the facility on 10/4/12 and had diagnoses which included, but were not limited to: senile dementia, adjustment disorder with depressed mood, and generalized anxiety disorder Review of Social Worker #1's note dated 10/15/12 indicated :" ...res [resident] d/c plans are to go home upon completion of therapy." A Social Worker #1's note dated 11/01/12 at 3:11 p.m., indicated "Spoke with resident and son about d/c planning and her current course of therapy. Res stated that before her admission, she independently cooked, cleaned, bathed, toileted, and walked. She expressed desire to do all of the above before d/c. Writer encouraged res to attend therapy sessions to meet her short term goal.. Will continue to encourage, motivate and assess for any changes or concerns. Social Worker #1's note dated 11/9/12 at 9:15 a.m., indicated "Set up meeting with resident's son regarding her non-compliance issues with therapy. Therapy, Social Services and ED [Executive Director] will attend."			

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	No further documentation regarding the resident's non-compliance with therapy and discharging planning could be located. A 10/25/12 PT [Physical Therapy] note indicated: "Pt [patient] needs max encouragement to participate with Physical Therapy and frequently refused therapy, even after importance of therapy explained. Pt has progressed with strengthening goal but is not progressing with transfers or showing consistent progress with gait" OT [Occupational Therapist] Therapist Progress and Discharge Summary: 11/1/12 - "The patient did not make significant progress towards goals. Attempted to adjust treatment plans and techniques to encourage pt participation. Patient with inappropriate actions and verbalization towards staff. Patient's son contacted multiple times with attempted interventions. Patient with poor motivation and initiation of task requiring max vc's [verbal cues]." ST [Speech Therapist] Therapist Progress and Discharge Summary: 11/9/12 -" The patient did not make significant progress this week towards			

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	goals d/t noncompliance with Speech Therapy POC [Plan of care]. Patient non-compliant with most Speech Therapy Hhhy tasks; decreased motivation to participate." Physical Therapist Progress and Discharge Summary: 11/1/12 - "Needs motivation to participate in therapy. D/C from Physical Therapy services secondary patient reached maximum benefits from therapy at this time." During an interview with Social Worker #1 on 12/17/12 at 3:20 p.m., she indicated "the resident was given a break from therapy after d/c in beginning of November in hopes that in a month she would feel more motivated. I talk with her all the time to encourage and motivate her. I don't know why I haven't documented on her since the November note. The son was aware of what was going on and was in agreement with putting therapy on hold for a month. He talked about building an addition on his house for her but she has to be able to do certain things before she could come home. I think therapy has picked her back up again and is currently being seen again so she can get stronger to go home."			

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	During an interview with the Speech Therapist and the Occupational Therapy Assistant on 12/17/12 at 3:25 p.m., they indicated the resident had not been picked back up again for therapy. 3.1-34(g)			

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F0272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. A. Based on record review and interview the facility failed to conduct an assessment on Resident #108 after there was a significant change in	F0272	F272 States that the facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility	01/19/2013

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	her condition. The affected 1 out of 2 residents reviewed for significant change assessments. (Resident #108) B. Based on record review and interview, the facility failed to initiate a skin assessment and ensure the accuracy of a skin assessment when the resident developed a rash on 2 separate occasions. This deficient practice affected 1 of 2 residents reviewed for skin impairments. (Resident #152) Findings include: A. Record review for Resident #108 was done on 12/13/12 at 3:05 p.m. This resident was admitted on 8/3/12 and then readmitted on 9/27/12 after she had been hospitalized on 9/24/12. Her diagnoses included but were not limited to: esophageal reflux, anxiety, chronic obstructive lung disease (COPD), anemia, and depression. Progress notes were received 12/17/12 at 2:40 p.m., from the Medical Records Designee. This resident was seen on 9/17/12 by psychiatric services. A note dated 9/19/12 stated, "Resident remains very disorientated..." There were no		must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:Identification and demographic information;Customary routine;Cognitive patterns;Communication;Vision;Mood and behavior patterns;Psychosocial well-being;Physical functioning and structural problems;Continence;Disease diagnosis and health conditions;Dental and nutritional status;Skin conditions;Activity pursuit;Medications;Special treatments and procedures;Discharge potential;Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); andDocumentation of participation in assessment.The facility will ensure this requirement is met through the following corrective measures:1. Resident #152's skin assessment was completed . Resident #108 significant change assessment was completed. 2. All residents who have had a recent or significant change in condition will be audited, by DNS or Designee, to ensure that an assessment has been initiated/completed. All	

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	previous notes of this resident being disoriented. On 9/20/12 a note stated, "...Resident was noted twice during this shift to enter another resident's room without permission..." On 9/21/12 the note indicated no signs or symptoms of confusion at 2:06 a.m. At 3:12 p.m., on 9/21/12 the note stated, "Is still confused today..." At 10:30 p.m., on 9/21/12 the note stated, "...Resident continues to be confused and rambles incoherently." On 9/22/12 at 2:49 a.m., the note indicated resident continued to be confused. On 9/22/12 at 12:55 p.m., the note stated, "Resident remains confused at most xs (times) and lethargic this shift. On 9/23/12 at 12:01 p.m., the note stated, "...Confusion noted..." On 9/24/12 at 12:12 p.m., the note indicated resident had been "more disorientated". A note on 9/24/12 at 4:55 p.m., stated, "Resident confused with paranoia noted. Pushing wheelchair around nursing without O 2 on...Mini neb (breathing treatment) given with O 2 saturation up to 90%..." They received an order to send the resident to the hospital and family was notified at this time. In reviewing the record there was no		resident's that have a recent skin integrity impairment will be audited, by DNS or Designee, to ensure an appropriate skin assessment has been completed. 3. The charge nurse who identifies the change in condition will contact the resident's physician and family to communicate the change. The charge nurse will document the nurses assessment/ actions/interventions in the nurses' notes and will add to daily charting. The DNS or Designee will review documentation to ensure physician and family are notified and assessment is completed . If the assessment is not completed appropriate action will be taken. Residents who develop a rash, or recent skin integrity event, will have a skin assessment completed by the charge nurse immediately upon notification. The DNS or Designee will review skin assessments to ensure the assessments are completed accurately and completely. Nursing will be in-serviced on the Skin Management Program Policy (see Attachment A) and the Change of Condition Policy by the DNS and Staff Development Coordinator, on or before January 17 th , 2013. 4. The DNS or designee will utilize the Continuous Quality Improvement Skin Management Program tool (see Attachment 272-1) to ensure	

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	notification made to the physician of the change in her condition with the confusion until 9/24/12 at 4:55 p.m., when there had been confusion for many days prior to this one. Review of the care plan dated 8/16/12 on 12/17/12 at 10:40 a.m., from Medical Records Designee, stated, "...resident also has respiratory problems which could be a contributing factor to cognitive ability at times..." There were no assessments found for this significant change in Resident #108's record. Interview with the Medical Records Designee on 12/17/12 at 10:40 a.m., she indicated there was not an assessment found for this resident for this time period. B. Review of the clinical record for Resident #152 on 12/13/12 at 4:31 p.m., indicated the resident was admitted to the facility on 10/4/12 and had diagnoses which included, but were not limited to: cellulitis/abscess leg and metastatic neoplasm bone and brain. MD progress notes indicated that on 11/13/12, the Nurse Practitioner [NP] saw the resident due to a rash which		that any residents with a skin integrity impairment has an appropriate assessment completed. Additionally, the DNS or designee will utilize the Continuous Quality Improvement Change of Condition tool(see Attachment 272-2) to ensure any residents who has experienced a significant change has a significant change assessment completed as appropriate weekly for 4 weeks, then monthly for 6 months, then quarterly thereafter. These audits will be reviewed during the facility's quarterly CQI meetings. . If a threshold of 95% is not met, the plan of action will be adjusted accordingly by the CQI committee. 5. The above corrective measures will be completed on or before January 17 th , 2013.	

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	was a red rash to the entire body which had started that day - the diagnosis the NP gave was "Dermatitis". Review of the nursing notes between 11/13/12 and 11/20/12 indicated the resident had developed a rash with occasional itch . Review of the November 2012 Physician Orders indicated a new order was received on 11/13/12 for Benadryl Allergy 25 mg [milligrams] tablet - initially QID [4 times a day] but then changed that day thru 11/16/12 to PRN [as needed]. On 11/15/2012 through 11/20/12, the resident received orders for Medrol Pak [a steriod]. On 11/15/12 - received 8 mg at 6 a.m. and 8 p.m., and 4 mg at noon and 6 p.m.. On 11/16/12 - received 8 mg at 8 p.m. and 4 mg at 7 a.m., noon, 6 p.m. On 11/17/12 - received 4 mg at 7 a.m., noon, 6 p.m., and 8 p.m. On 11/18/12 - received 4 mg at 7 a.m., noon and 8 p.m. On 11/19/12 - received 4 mg at 7 a.m. and 8 p.m. On 11/20/12 - received 4 mg at 7 a.m. Review of the 11/13/12 Weekly Nursing Summary and Skin			

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	Assessment completed at 3:09 p.m., indicated the resident had some edema in BLE [Bilateral Lower Extremities] since last review; but skin was warm and dry and pink with no s/s [signs/symptoms] of rash or irritation. Nursing notes between 12/10/12 and 12/12/12 indicated the following: - "12/10/12 5:08 p.m. - Left message with NP regarding rash and itching. Will continue to monitor. - 10:17 p.m. - No new orders received at this time regarding rash." Last skin assessment was completed on 12/10/12 which indicated the resident's skin was warm dry and intact - no dryness or skin irritation was noted. -"12/11/12 1:44 a.m. -...resident resting abed at this time with no s/s of distress noted. -2:28 a.m. -itching and rash continues. Resident is resting at this time but has periodically gotten up with c/o[complaint of] itching. MD aware. Will continue to monitor. -11:58 am -...Skin warm, dry and intact..." "12/12/12 3:56 PM -...Skin is warm and dry."			

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	"12/13/12 1:40 p.m. -...skin warm dry and intact." On 12/14/12 at noon, the nursing notes were reviewed with LPN #1. She indicated both nurses did not record where the location of the rash was at and should have created an event to document on it. She also indicated she would check the daily sheets to see if they documented on that about the rash. At 12:25 p.m. - the LPN indicated "I checked the daily reports and the rash is on there, mostly written as dry skin. I looked at her and she has lotion and the day shift nurse told me it is mainly dry skin but there should have been more of an assessment done to indicate where the rash was and what it looked like." A policy titled, "Resident Assessment" was received on 12/17/12 at 2:54 p.m. This policy stated, "...Procedure: 1. The facility will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity not less than annually..." 3.1-31(d)(1)			

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F0279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to ensure a care plan was developed for a resident who had a rash on 2 separate occasions (Resident #152); for a resident who was admitted for short-term rehabilitation and planned on going home (Resident #159); for a resident with mood and behavior issues of non-compliance with therapy (Resident #81) and for a resident with chronic pain (Resident #171). This deficient practice affected 4 of 29 residents reviewed for care	F0279	F279 States that a facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	01/19/2013

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	155165	A. BUILDING 00 B. WING	12/18/2012

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	planning. Findings include: 1. Review of the clinical record for Resident #152 on 12/13/12 at 4:31 p.m., indicated the resident was admitted to the facility on 10/4/12 and had diagnoses which included, but were not limited to: cellulitis/abscess leg and metastatic neoplasm bone and brain. Review of the nursing notes between 11/13/12 and 11/20/12 indicated the resident had developed a rash with occasional itch. Review of the MD progress notes indicated that on 11/13/12, the Nurse Practitioner [NP] saw the resident due to a rash which was a red rash to the entire body which had started that day - the diagnosis the NP gave was "Dermatitis". Review of the November 2012 Physician Orders indicated a new order was received on 11/13/12 for Benadryl Allergy 25 mg tablet - initially QID [4 times a day] but then changed that day thru 11/16/12 to PRN [as needed]. On 11/15/12 through 11/20/12, the resident also received orders for Medrol Pak [a		required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).The facility will ensure this requirement is met through the following corrective measures:1. Care plans for residents #152, #81, and #171 were updated as appropriate. Resident #159 discharged home.2. All residents who have skin integrity impairment, the plan to discharge home, residents with non-compliance with therapy, and who have chronic pain have the potential to be affected. All residents who have a recent skin integrity impairment, the plan to discharge home, are non-compliant with therapy, and who have chronic pain will be audited by DNS or designee to ensure care plans are current and appropriate. 3. Residents who develop a rash will have a care plan initiated, by the charge nurse, MDS, or designee, that reflects the current condition of the skin. Residents who are admitted and plan on returning home, will have a care plan initiated by Social Services or designee. Residents who are non-compliant with therapy will have a care plan initiated by Social Services or designee to address refusal of treatments. Residents who designates he or	

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	steroid]. Nursing notes between 12/10/12 and 12/12/12 indicated the following: -"2/10/12 5:08 p.m.-Left message with NP regarding rash and itching. Will continue to monitor. -10:17 p.m.-No new orders received at this time regarding rash." -"12/11/12 1:44 a.m.-...resident resting abed at this time with no s/s of distress noted. -2:28 a.m. itching and rash continues. Resident is resting at this time but has periodically gotten up with c/o itching. MD aware. Will continue to monitor." Documentation was lacking of a care plan which addressed the red rash on both dates. A 10/11/12 Care Plan only addressed the resident as being at risk for skin breakdown or further breakdown due to: need for assistance with bed mobility, incontinence, complicated by impaired cognition with approaches included, but was not limited to: "assess and document skin condition weekly and as needed. Notify MD of abnormal findings. Preventative treatment as ordered." On 12/14/12 at noon, LPN #1		she is in pain, will have a care plan initiated that reflects pain assessment by the nurse, MDS, or designee. Care plan meetings will be held for each resident at a minimum each quarter and care plans updated as necessary by the IDT at that time. Nursing, Social Services, and MDS staff will be in-serviced on The Care Plan Review and Maintenance Policy (see Attachment A and Attachment 279-1) by the DNS and Staff Development Coordinator on or before January 17 th , 2013. 4. The DNS or designee will utilize the Care Plan Audit Tools (see Attachment 279-3 and Attachment 279-2) to ensure that any resident that has a skin integrity impairment, the plan to discharge home, are non-compliant with therapy, or who have chronic pain, have a comprehensive care plan completed as appropriate weekly for 4 weeks, then monthly for 6 months, then quarterly thereafter. These audits will be reviewed during the facility's quarterly CQI meetings. If a threshold of 95% is not met, the plan of action will be adjusted accordingly by the CQI committee. 5. The above corrective measures will be completed on or before January 17 th , 2013.	

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	indicated the care plans should have been updated to address the resident's skin rash issues. 2. Review of the clinical record for Resident #159 on 12/17/12 at 10:09 a.m., indicated the resident was admitted on 9/21/12 and had diagnoses which included: chronic airway obstruction - chronic with exacerbation; bipolar disorder, agoraphobia with panic disorder; post traumatic stress disorder, anxiety state, chronic pain, and schizophrenia. A Social Services note dated 9/26/12 at 2:30 p.m., indicated "...Resident plans to live with [name of family member] upon d/c from facility..." A Social Services note dated 9/26/12 at 2:27 p.m., indicated "spoke with resident at length regarding some concerns she is experiencing. She stated that she wanted to d/c [discharge] to [name of facilities]. She is currently under the care of therapist [name of agency]. The resident requested that I speak with her therapist about her d/c plans and any other concerns...Resident has an apartment that is in her name, but [name of person] was living there now. She does not want to go back to			

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	the apt for reasons of it having mold issues....Will f/u [follow up] with resident for encouragement, motivation and any new or existing concerns or problems." A Social Services note dated 11/27/12 at 3:17 p.m.,"Res came to writer to discuss d/c plans. She stated that she wants to leave the facility in a couple of weeks and has secured an assisted living apartment. Writer assured resident that all d/c planning would be coordinated before her departure. Will continue to f/u with d/c planning prn." No further notes could be located. During an interview with the resident on 12/12/12 at 10:00 a.m., she indicated she was going to be discharged from the facility on 12/21/12. A second interview with the resident on 12/17/12 at 1:30 p.m., indicated she was planning on going to a new apartment situation on 12/20/12 and that all arrangements and consents had been developed and set-up by the facility Social Worker, MD and a case worker from an outside agency. Review of the 9/28/12 Admission MDS [Minimum Data Set]			

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	Assessment indicated: Resident expects to be discharged to the community. No care plan could be located which addressed Discharge Planning. During an interview with Social Worker # 1 on 12/17/12 at 1:35 p.m., she indicated that she had only just started working in the facility 11/1/12 and that the resident came in before she started. She indicated that there should have been a care plan by Social Services right after admission as the resident's code status and discharge status are to be done right away on a care plan. 3. Review of the clinical record for Resident #81 on 12/17/12 at 2:00 p.m., indicated the resident was admitted from the hospital on 10/4/12 and had diagnoses which included, but were not limited: senile dementia, adjustment disorder with depressed mood, and generalized anxiety disorder. SW [Social Worker] #1 note dated 11/01/12 at 3:11 p.m., "Spoke with resident and son about d/c planning and her current course of therapy. Resident stated that before her admission, she independently cooked, cleaned, bathed, toileted,			

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	and walked. She expressed desire to do all of the above before d/c. Writer encouraged res to attend therapy sessions to meet her short term goal.. Will continue to encourage, motivate and assess for any changes or concerns." A SW #1 note dated 11/9/12 at 9:15 a.m. indicated "Set up meeting with resident's son regarding her non-compliance issues with therapy. Therapy, Social Services and ED [executive director] will attend." OT [Occupational Therapy] Therapist Progress and Discharge Summary: 11/1/12 The patient did not make significant progress towards goals. Attempted to adjust treatment plans and techniques to encourage patient participation. Patient with inappropriate actions and verbalization towards staff. Patient's son contacted multiple times with attempted interventions. Patient with poor motivation and initiation of task requiring max vc's [v erbal cues]. ST [Speech Therapy] Therapist Progress and Discharge Summary: 11/9/12 - The patient did not make significant progress this week towards goals d/t [due to] noncompliance with Speech Therapy POC [Plan of Care].			

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	Patient non-compliant with most Speech Therapy tasks; decreased motivation to participate. A 10/25/12 PT {Physical Therapy] note indicated "Patient needs max encouragement to participate with Physical Therapy and frequently refused therapy, even after importance of therapy explained. Patient has progressed with strengthening goal but is not progressing with transfers or showing consistent progress with gait." PT [Physical Therapy] Therapist Progress and Discharge Summary: 11/1/12 - Needs motivation to participate in therapy. D/C from Physical Therapy services secondary patient reached maximum benefits from therapy at this time. A care plan which addressed the resident's non-compliance behaviors of refusing therapy was lacking. 4. Record review for Resident #171 was done on 12/12/12 at 1:45 p.m. She was admitted on 12/10/12 with diagnoses which included but were not limited to: Diabetes, high blood pressure, anxiety disorder, chronic airway obstruction, dementia, chronic pain syndrome and ischemic heart disease. The pain assessment done			

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	on 12/10/12 indicated this resident had neck pain frequently but there was no order for any kind of pain medication. Interview with the resident on 12/12/12 at 4:35 p.m., she indicated she has constant neck pain. She stated, "Pain medicine helps but does not take it away. During this interview a nurse came in the room to give her medications. She told the nurse about the pain. The nurse told her she would call the doctor and get an order for her pain medication. As of 12/14/12 at 12:49 p.m., there was no documentation that the doctor had been notified this resident needed something for pain. Orders were received on 12/17/12 at 8:45 a.m., from the Medical Records Designee. She indicated the doctor just signed them on Friday (12/14/12). There was still no order for any pain medicine. On 12/17/12 at 2:30 p.m., we received a copy of an order for Tylenol 325 mg 2 tablets every 6 hours as needed for pain. The date on the order was 12/17/12. As of 12/17/12 at 2:30 p.m., there was no care plan for the chronic pain			

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	this resident had. On 12/14/12 at 1:20 p.m., LPN #1 presented a copy of the facility's current Policy on "Care Plan Review and Maintenance Process." Review of the policy at this time included, but was not limited to: "Policy: It is the policy of this facility that each resident will have a comprehensive care plan developed based on comprehensive assessment. The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning...Procedure:...Care plan problems, goals, and interventions will be updated based on changes in resident assessment/condition,..." 3.1-35(a) 3.1-35(b)(1)			

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F0280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. A. Based on record review and interview, the facility failed to update the Social Service care plan for Discharge Planning when the resident's plans for discharge to home after rehabilitation had changed to long term care. This deficient practice affected 1 of 5 residents reviewed for social service care plans (Resident #81) B. Based on record review, observations and interviews, the facility failed to have a care plan revision to address a resident's change to long term care , 2 residents	F0280	F280 States that the resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the	01/19/2013

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	had no change in interventions after falls and 1 resident's change in condition. This affected 3 of 11 residents reviewed for care plan revisions. (Residents #64, 31 and 108) Finding includes: A. Review of the clinical record for Resident #81 on 12/13/12 at 4:31 p.m., indicated the resident was admitted to the facility on 10/4/12 and had diagnoses which included, but were not limited to: cellulitis/abscess leg and metastatic neoplasm bone and brain. Review of Social Worker #1's note dated 10/15/12 indicated: "...res [resident] d/c [discharge] plans are to go home upon completion of therapy." A Social Worker #1 note dated 11/01/12 at 3:11 p.m.,. indicated: "Spoke with resident and son about d/c[discharge] planning and her current course of therapy. Res [resident] stated that before her admission, she independently cooked, cleaned, bathed, toileted, and walked. She expressed desire to do all of the above before d/c. Writer encouraged res to attend therapy		resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. The facility will ensure this requirement is met through the following corrective measures:1. Resident # 81, #64, #31 and #108 care plans and interventions have been updated to reflect the resident's current status. 2. All residents who have the plan to discharge home, who has had a recent fall, or a change in condition have the potential to be affected. All residents who have the goal to discharge home, have experienced a recent fall or have had a recent change in condition will be audited by DNS or Designee to ensure the accuracy of the resident's care plan. 3. If resident experiences a fall, fall interventions will be reviewed and revised, care plan will be revised and any new orders will become part of the care plan. The DNS, MDS, or Designee will be responsible for the care plan revision. Any new fall intervention will be incorporated into the care plan and C.N.A. assignment sheets. The Social Services Director or designee will complete upon discharge the discharge to home check list (see Attachment 280-1). The IDT will review the form to ensure all arrangements are met. Any resident who is designated to discharge home and, it is identified that they are	

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	sessions to meet her short term goal.. Will continue to encourage, motivate and assess for any changes or concerns." Social Worker #1's note dated 11/9/12 at 9:15 a.m., indicated: "Set up meeting with resident's son regarding her non-compliance issues with therapy. Therapy, Social Services and ED will attend." A 10/16/12 Admission MDS [Minimum Data Set] Assessment indicated the resident scored a 14 on her BIMS [brief interview of mental status] test - cognitively intact; no mood or behavior issues; Under the "Discharge Plan" section of the MDS - an active discharge plan was not occurring for resident's return to the community. A 10/17/12 Care plan was developed for "Resident plans to return to the community" Goal : Resident will be discharged to her home. Approaches: explore with resident and family needs to transition to the community (home care, DME [durable medical equipment], MOWs [meals on wheels], etc); Offer home evaluation as appropriate; referral to outside agency as appropriate."		unable to do so, the resident's care plan will be updated by the Social Services Director or designee at that time to ensure proper plans are in place. All nursing staff and IDT will be in-serviced on the Care Plan Review and Maintenance Process (see Attachment A and Attachment 280-2) by the DNS and Staff Development Coordinator on or before January 17 th , 2013. 4. The DNS or designee will utilize the Continuous Quality Improvement Care Plan Review tool (see Attachment 280-4)and the Continuous Quality Improvement Care Plan Updating tool (see Attachment 280-3) to ensure that care plans are accurate and updated as appropriate weekly for 4 weeks, then monthly for 6 months, then quarterly thereafter. These audits will be reviewed during the facility's quarterly CQI meetings. If a threshold of 95% is not met, the plan of action will be adjusted accordingly by the CQI committee. 5. The above corrective measures will be completed on or before January 17 th , 2013.	

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	The OT [occupational therapist] Therapist Progress and Discharge Summary dated 11/1/12 indicated "The patient did not make significant progress towards goals. Attempted to adjust treatment plans and techniques to encourage pt participation. Pt with inappropriate actions and verbalization towards staff. Pt's son contacted multiple times with attempted interventions. Pt with poor motivation and initiation of task requiring max vc's [verbal cues]. Long term Care" The ST [speech therapist] Therapist Progress and Discharge Summary dated 11/9/12 indicated "The patient did not make significant progress this week towards goals d/t [due to]noncompliance with ST POC. Patient non-compliant with most ST tasks; decreased motivation to participate." The PT [physical therapist] Therapist Progress and Discharge Summary dated 11/1/12 indicated "Needs motivation to participate in therapy. D/C from Physical Therapy services secondary patient reached maximum benefits from therapy at this time - 24 hour supervision."			

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	A 10/25/12 Physical Therapy note indicated "Patient needs max [maximum] encouragement to participate with Physical Therapy and frequently refused therapy, even after importance of therapy explained. Patient has progressed with strengthening goal but is not progressing with transfers or showing consistent progress with gait." Documentation was lacking of the care plan having been updated to reflect the resident now requiring long term care instead of going home. During an interview on 12/17/12 at 3:20 p.m. with Social Worker #1, she indicated she didn't know why she hasn't documented on the resident since the November note. On 12/14/12 at 1:20 p.m., LPN #1 presented a copy of the facility's current Policy on "Care Plan Review and Maintenance Process."...Procedure:...Care plan problems, goals, and interventions will be updated based on changes in resident assessment/condition,..." B. 1. Resident #64's record was reviewed on 12/13/12 at 3:05 p.m. The record indicated Resident #64 had diagnoses that included, but were not limited to, muscle weakness,			

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	history of urinary tract infection, difficulty in walking, psychosis, senile, dementia with behavioral disturbances, high blood pressure, ischemic heart disease, atrial fibrillation, and intracranial hemorrhage. A quarterly Minimum Data Set Assessment (MDS) dated 8/28/12 indicated Resident #64 was moderately impaired in cognitive skills for daily decision making and has had falls since admission with minor injuries. Progress notes, dated 12/13/12 at 1:00 p.m., indicated: "Resident transferring self from w/c (wheelchair) to bed. Resident slid from chair to floor. Fall unwitnessed, resident denies any pain r/t (related to) fall at this time. 0 marks noted. Educated resident on use of call light for assistance, also to wear nonskid socks during transfer. Call light in reach. Will cont[inue] to monitor during shift." A fall investigation, dated 12/13/12, indicated Resident #64 fell in her room on 12/13/12 at 1:12 p.m. and was found sitting on the floor next to the bed. She had been dressed in clothes and wearing gripper socks			

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	and the fall was unwitnessed. The resident didn't complain of pain and had not been incontinent. There was no clutter or environmental factors and the new intervention was "Resident will attend dining room [for meals]". Progress notes, dated 11/24/12 at 11:34 a.m., indicated: "Resident found in the floor setting up. Resident stated she slid out of her bed trying to get a pencil. Resident had on non-skid socks. Educated resident on using the call light when need help transferring. Resident has 0 injurys (sic) noted. Will cont to monitor during shift." A fall investigation, dated 11/24/12, indicated Resident #64 fell on 11/24/12 at 11:28 a.m. The fall was unwitnessed, the resident had been resting in bed, then was found sitting on the floor. The resident was wearing non skid socks, did not complain of pain, and no injuries were observed. The resident stated she was "trying to get a pencil" and was not observed to be incontinent at the time of the fall. The new intervention was "Educted (sic) resident on using call light for assistance". The intervention for use of the call			

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	light was already part of the care plan, and no other interventions were initiated. Progress notes, dated 11/26/12 at 9:53 a.m., indicated: "Fall review with DNS (Director of Nursing Services), Therapy, Dietary, and Unit Manager. Resident had an unwitnessed fall on 11/24/12 at 1134 am. Family notified at 1138 am, MD notified at 1138 am. Prior to fall resident was lying in bed. When staff entered room resident was sitting on the floor next to bed. She was dressed with gripper socks on. Full body assessment was completed per nurse...Resident reported she dropped her pencil and was trying to pick it up. Intervention: Therapy to screen for a reacher device." Progress notes, dated 9/22/12 at 10:30 a.m., indicated: "Resident yelled for nurse as nurse was passing by room. Resident found on the floor leaned up against her w/c. Resident was trying to transfer self form bed to w/c. Resident was not wearing non skid, or shoes at time of fall. Resident stated she did not hit her head. No injuries noted. Educated resident on using call light, and the importance of wearing non skid attire. Notified MD, Family and RN			

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	supervisor. Will cont to monitor." A fall investigation, dated 9/22/12, indicated Resident #64 fell on 9/22/12 at 11:43 a.m. and the fall was unwitnessed. The resident had been in bed, was found sitting up against her wheel chair in her room, and was dressed with socks on. The resident had no complaints of pain, had no injuries, and stated she was "getting out of bed to get in her wheel chair". The resident had not been incontinent at the time of the fall. The new intervention was to put tennis shoes on the resident, and "Educated res on the use of call light and wearing non skid attire." The intervention for use of the call light was already part of the care plan and no other interventions were initiated. Review of care plans dated 3/3/12 indicated a goal of "Resident will have no injury related to falls." Interventions with dates included, but were not limited to: "12/13/12: Resident to attend Dining Room for meals. 11/26/12: Therapy to screen for use of a reacher device. 9/24/12: Remove w/c from bedside. 9/24/12: Use touch call light. 7/9/12: 10:30 pm to 7am to get up in am. 4/18/12:			

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	Keep bathroom light on during the night. 4/09/12: Keep foot of bed at lowest position. 5/27/11 indicated: Encourage and remind resident to use call light. Encourage continued participation in ordered therapies. Fall risk assessment. Observe for fall risk contributors such as medications, hypotension, pain, unsteady gait. Provide appropriate assistive devices such as walker, low bed, mats on floor, alarms on chair/bed. Provide assistance for transfers, bed mobility." During an interview on 11/24/12 at 1:50 p.m., Speech Therapist #4 indicated she looked for an evaluation for the reacher but did not find where one had been done. During an interview on 12/18/12 at 1:58 p.m., Occupational Therapist #5 indicated she looked for a screening for the reacher but couldn't find where one had been done. During an interview on 12/18/12 at 2:17 p.m., Unit Manager #6 indicated she had told the Therapist [#5] who was in the IDT meeting that Resident #64 needed a screen, and she would check to see what happened after that. During an interview on 12/18/12 at			

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	3:13 p.m., the Director of Health Services (DHS) indicated that OT (occupational therapy), PT (physical therapy), and ST (speech therapy) had determined the reacher would not be an appropriate intervention, that this was an isolated fall and the interventions in place were appropriate. B. 2. Record review for Resident #108 was done on 12/13/12 at 3:05 p.m. This resident was admitted on 8/3/12 and then readmitted on 9/27/12 after she had been hospitalized on 9/24/12. Her diagnoses included but were not limited to: esophageal reflux, anxiety, chronic obstructive lung disease (COPD), anemia, and depression. According to the Progress Notes dated 9/17/12 through 9/24/12 Resident #108 was having confusion and disorientation. There were no interventions put into place on her care plan since 8/16/12. B. 3. Record review for Resident #31 was done on 12/17/12 at 4:10 p.m. She was admitted on 2/28/2007. Her diagnoses included but were not limited to: Osteoarthrosis, dementia with depression and behaviors, mental disorder, difficulty walking, History of strokes, convulsions,			

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	aphasia, depressive disorder and hearing loss. During review of the progress notes it was found that this resident had had 2 falls earlier this month (12/6 and 12/7/12). It was also noted that the care plan for falls had not been updated since 11/4/11. There were no new interventions in place since the 2 falls. Interview with LPN #2 on 12/17/12 at 1:30 p.m., she indicated changes are made to the care plans when there is a change in the resident's condition and/or activities. "It is the nurses responsibility to update them or be sure the Director of Nursing is made aware so she can have someone update it." A policy and procedure for a "Fall Management Program", with a revised date of 6/2012, indicated "Policy: It is the policy of American Senior Communities to ensure residents residing within the facility will maintain maximum physical functioning through the establishment of physical, environmental, and psychosocial guidelines to prevent injury related to falls. Procedure...4. A fall event will be initiated as soon as the resident has been assessed and cared for. The report must be completed in full in order to identify			

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	possible root causes of the fall and provide immediate interventions. An entry will be completed in the EMR (Electronic Medical Record) addressing the fall, any injuries, physician and family notification, and interventions initiated. 5. All falls will be discussed by the interdisciplinary team the next business day morning after the day of the fall to determine other possible interventions to prevent future falls...The care plan will be reviewed and updated, as necessary." 3.1-35(d)(2)(B) 3.1-35(e)			

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A. Based on record review and interview the facility failed to ensure Resident #108 received the care and services she needed in that when she became confused there was no notification to the doctor and no assessment or care plan update until it had been going on for 5 days. This affected 1 of 20 residents reviewed for proper care and services. (Resident # 108) B. Based on record review and interview, the facility failed to ensure a resident with a skin rash received treatment to alleviate the itching. This deficient practice affected 1 of 2 residents reviewed for skin conditions. (Resident #152) Findings include: A. Record review for Resident #108 was done on 12/13/12 at 3:05 p.m. This resident was admitted on 8/3/12 and then readmitted on 9/27/12 after	F0309	F309 States that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The facility will ensure this requirement is met through the following corrective measures:1. Resident #108 current condition has been reviewed by the IDT team and communicated to physician and family. Additionally, resident #108 care plan has been updated. The DNS assessed resident #152 and rash has cleared.2. All residents who have a change in condition or impaired skin integrity have the potential to be affected. All residents who have a recent change in condition, or a recent impaired skin integrity event, will be audited by the DNS or designee, to ensure that family and physicians have been notified about change of condition and care plans are updated and that residents with impaired skin	01/19/2013

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	she had been hospitalized on 9/24/12. Her diagnoses included but were not limited to: esophageal reflux, anxiety, chronic obstructive lung disease (COPD), anemia, and depression. Resident #108 was experiencing confusion and disorientation. The facility documented it was happening but there was no assessment done and there was no documentation in the record of the physician notification. The resident was confused for 5 days before the doctor was called and she was sent to the hospital. Interview with LPN #5 on 12/17/12 at 11:00 a.m., she indicated this resident was doing much better now that she keeps her oxygen on better. There should always be notification to the doctor of a change in condition.		integrity have appropriate treatments.3. The charge nurse who identifies the change in condition will contact the resident's physician and family to communicate the change. The charge nurse will document the nurse's assessment/ actions/interventions in the nurses' notes and will add to the daily charting. The DNS or designee will review documentation to ensure physician and family are notified and assessment is completed . If the assessment is not completed, appropriate action will be taken. Residents who develop a rash, or a recent skin integrity event, will have a skin assessment completed by the charge nurse immediately upon notification. The DNS or designee will review skin assessments to ensure the assessments are completed accurately and completely. The IDT will develop a care plan based on the skin assessment. All nursing and IDT team will be in-serviced on or before January 17 th , 2013, by the DNS and Staff Development Coordinator, on the Skin Management Policy and Procedure, Care Plan Policy, and the Change of Condition Policy (see Attachment A and Attachment 309-1). 4. The DNS or designee will utilize the Continuous Quality Improvement Skin Management Program tool (see Attachment 309-5), Change	

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	B. Review of the clinical record for Resident #152 on 12/13/12 at 4:31 p.m., indicated the resident was admitted to the facility on 10/4/12 and had diagnoses which included, but were not limited to: cellulitis/abscess leg and metastatic neoplasm bone and brain. Nursing notes between 12/10/12 and 12/12/12 indicated the following: -"12/10/12 5:08 p.m. - Left message with Nurse Practitioner [NP] regarding rash and itching. Will continue to monitor. -10:17 p.m. - No new orders received at this time regarding rash."		of Condition Program tool (see Attachment 309-4), and the Care Plan Review tools (see Attachment 309-2, 309-3), to ensure that change of conditions, care plan review, and impaired skin integrity assessments and treatments are completed as appropriate weekly for 4 weeks, then monthly for 6 months, then quarterly thereafter. These audits will be reviewed during the facility's quarterly CQI meetings. If a threshold of 95% is not met, the plan of action will be adjusted accordingly by the CQI committee. 5. The above corrective measures will be completed on or before January 17 th , 2013.	

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	-"12/11/12 1:44 a.m. -...resident resting abed at this time with no s/s of distress noted. -2:28 a.m.- itching and rash continues. Resident is resting at this time but has periodically gotten up with c/o itching. MD aware. Will continue to monitor." On 12/17/12 at 12:25 p.m., LPN #1 indicated "I checked the daily reports and the rash is on there, mostly written as dry skin. I looked at her and the day shift nurse said it is mainly just dry skin." No documentation was found of the staff appling lotion to the resident's skin to help with dry skin and itching. During an Interview with LPN #2 at 1:00 p.m., on 12/14/12, she indicated she had just completed a full skin assessment on the resident per request as it was observed the resident had a rash. She indicated that during the assessment, nothing was observed on the resident at this time and that she believed it was just dry skin. She reviewed the MD orders and indicated that the resident did not have any specific orders for lotion to treat dry skin. The LPN also indicated that the resident did have a tendency to scratch her dry skin and make it			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, observation, and interview, the facility failed to ensure residents were free from falls and fall hazards in that 2 residents had falls with no appropriate, new interventions after the falls to prevent further falls. This affected 2 of 4 residents reviewed for supervision to prevent accidents. (Residents # 64 and #31) The findings include: 1. Resident #64's record was reviewed on 12/13/12 at 3:05 p.m. The record indicated Resident #64 had diagnoses that included, but were not limited to, muscle weakness, history of urinary tract infection, difficulty in walking, psychosis, senile, dementia with behavioral disturbances, high blood pressure, ischemic heart disease, atrial fibrillation, and intracranial hemorrhage. A quarterly Minimum Data Set	F0323	F323 States that the facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. The facility will ensure this requirement is met through the following corrective measures:1. Resident #64 and #31's fall interventions and care plans were reviewed and updated. 2. All residents who have experienced a recent fall have the potential to be affected. All residents with recent falls will be audited by DNS or Designee to ensure care plans and interventions are still appropriate and in place.3. If resident experiences a fall, fall interventions will be reviewed and revised, care plan will be revised and any new orders will become part of the care plan. The DNS/Designee will be responsible for the care plan revision. Any new fall intervention will be incorporated into the care plan and C.N.A assignment sheets.Nursing staff will be in-serviced on or before January 17 th , 2013, by the DNS and	01/19/2013

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Assessment (MDS) dated 8/28/12 indicated Resident #64 was moderately impaired in cognitive skills for daily decision making and has had falls since admission with minor injuries. Progress notes, dated 12/13/12 at 1:00 p.m., indicated: "Resident transferring self from w/c (wheelchair) to bed. Resident slid from chair to floor. Fall unwitnessed, resident denies any pain r/t (related to) fall at this time. 0 marks noted. Educated resident on use of call light for assistance, also to wear nonskid socks during transfer. Call light in reach. Will cont[inue] to monitor during shift." A fall investigation, dated 12/13/12, indicated Resident #64 fell in her room on 12/13/12 at 1:12 p.m., and was found sitting on the floor next to the bed. She had been dressed in clothes and wearing gripper socks and the fall was unwitnessed. The resident didn't complain of pain and had not been incontinent. There was no clutter or environmental factors and the new intervention was "Resident will attend dining room [for meals]". Progress notes, dated 11/24/12 at		Staff Development Coordinator on the Fall Management procedure (see attachment A). All residents who had a fall will have an immediate intervention initiated. The ASC Fall Event will be reviewed during the clinical IDT meeting on the following business day to ensure interventions to the fall are appropriate. If, during this time, the intervention is not appropriate, then the IDT team will initiate a more appropriate intervention. 4. The DNS or her designee will utilize the CQI Quality Indicator Falls Management tool (see Attachment F323-1) to ensure residents' fall interventions are appropriate weekly for 4 weeks, then monthly for 6 months, then quarterly thereafter. These audits will be reviewed during the facility's quarterly CQI meetings and the plan of action adjusted accordingly. If a threshold of 95% is not met, the plan of action will be adjusted accordingly by the CQI committee. 5. The above corrective measures will be completed on or before January 17 th , 2013.	

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	155165	A. BUILDING 00 B. WING	12/18/2012

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	11:34 a.m., indicated: "Resident found in the floor setting up. Resident stated she slid out of her bed trying to get a pencil. Resident had on non-skid socks. Educated resident on using the call light when need help transferring. Resident has 0 injurys (sic) noted. Will cont to monitor during shift." A fall investigation, dated 11/24/12, indicated Resident #64 fell on 11/24/12 at 11:28 a.m. The fall was unwitnessed, the resident had been resting in bed, then was found sitting on the floor. The resident was wearing non skid socks, did not complain of pain, and no injuries were observed. The resident stated she was "trying to get a pencil" and was not observed to be incontinent at the time of the fall. The new intervention was "Educted (sic) resident on using call light for assistance". The intervention for use of the call light was already part of the care plan, and no other interventions were initiated. Progress notes, dated 11/26/12 at 9:53 a.m., indicated: "Fall review with DNS (Director of Nursing Services), Therapy, Dietary, and Unit Manager. Resident had an unwitnessed fall on			

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	11/24/12 at 1134 am. Family notified at 1138 am, MD notified at 1138 am. Prior to fall resident was lying in bed. When staff entered room resident was sitting on the floor next to bed. She was dressed with gripper socks on. Full body assessment was completed per nurse...Resident reported she dropped her pencil and was trying to pick it up. Intervention: Therapy to screen for a reacher device." Progress notes, dated 9/22/12 at 10:30 a.m., indicated: "Resident yelled for nurse as nurse was passing by room. Resident found on the floor leaned up against her w/c. Resident was trying to transfer self form bed to w/c. Resident was not wearing non skid, or shoes at time of fall. Resident stated she did not hit her head. No injuries noted. Educated resident on using call light, and the importance of wearing non skid attire. Notified MD, Family and RN supervisor. Will cont to monitor." A fall investigation, dated 9/22/12, indicated Resident #64 fell on 9/22/12 at 11:43 a.m., and the fall was unwitnessed. The resident had been in bed, was found sitting up against her wheel chair in her room, and was dressed with socks on. The resident			

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	had no complaints of pain, had no injuries, and stated she was "getting out of bed to get in her wheel chair". The resident had not been incontinent at the time of the fall. The new intervention was to put tennis shoes on the resident, and "Educated res on the use of call light and wearing non skid attire." The intervention for use of the call light was already part of the care plan and no other interventions were initiated. Review of care plans dated 3/3/12 indicated a goal of "Resident will have no injury related to falls." Interventions with dates included, but were not limited to: "12/13/12: Resident to attend Dining Room for meals. 11/26/12: Therapy to screen for use of a reacher device. 9/24/12: Remove w/c from bedside. 9/24/12: Use touch call light. 7/9/12: 10:30 pm to 7am to get up in am. 4/18/12: Keep bathroom light on during the night. 4/09/12: Keep foot of bed at lowest position. 5/27/11 indicated: Encourage and remind resident to use call light. Encourage continued participation in ordered therapies. Fall risk assessment. Observe for fall risk contributors such as medications, hypotension, pain, unsteady gait.			

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	Provide appropriate assistive devices such as walker, low bed, mats on floor, alarms on chair/bed. Provide assistance for transfers, bed mobility." During an interview on 11/24/12 at 1:50 p.m., Speech Therapist #4 indicated she looked for an evaluation for the reacher but did not find where one had been done. During an interview on 12/18/12 at 1:58 p.m., Occupational Therapist #5 indicated she looked for a screening for the reacher but couldn't find where one had been done. During an interview on 12/18/12 at 2:17 p.m., Unit Manager #6 indicated she had told the Therapist [#5] who was in the IDT meeting that Resident #64 needed a screen, and she would check to see what happened after that. During an interview on 12/18/12 at 3:13 p.m., the Director of Health Services (DHS) indicated that OT (occupational therapy), PT (physical therapy), and ST (speech therapy) had determined the reacher would not be an appropriate intervention, that this was an isolated fall and the interventions in place were appropriate.			

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	2. Record review for Resident #31 was done on 12/17/12 at 4:10 p.m. She was admitted on 2/28/2007 Diagnoses included but were not limited to: Osteoarthrosis, Dementia with depression and behaviors, mental disorder, difficulty walking, backache, convulsions, aphasia, psychosis, anxiety, depressive disorder, hearing loss, high blood pressure, congestive heart failure, anemia, hypothyroidism, ischemic heart disease. Resident #31 had a fall on 12/6/12 and on 12/7/12. Care plan interventions had not been updated for falls since 11/4/11. After 2 falls there were no new interventions made in her care to prevent further falls. Upon entering Resident #31's room on 12/17/12 at 3:10 p.m., her dresser was sitting at the foot of her bed with a TV sitting on top of it. There were electrical wires (cords) running from the wall to the things on the dresser. The resident was sitting on her bed on the side closest to the outside wall. To get out from that side of the bed, she either had to walk over the cords or maneuver herself over the bed. LPN #3 came into the room to assist Resident #31. She indicated she did			

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	not know for sure why the room was set up this way unless it was so she could read the captions on the TV since she can't hear very well. Interview with LPN #4 on 12/17/12 at 3:20 p.m., she indicated the dresser had been that way since she started working in the facility. She thought it was pulled out from the wall so the resident could read the screen. "She sits on her bed and moves from side to side." Interview with the Maintenance Supervisor on 12/17/12 at 4:03 p.m., he indicated they would mount her TV on the wall and move the dresser back to prevent the fall hazard. A policy and procedure for a "Fall Management Program", with a revised date of 6/2012, indicated "Policy: It is the policy of American Senior Communities to ensure residents residing within the facility will maintain maximum physical functioning through the establishment of physical, environmental, and psychosocial guidelines to prevent injury related to falls. Procedure...4. A fall event will be initiated as soon as the resident has been assessed and cared for. The report must be completed in full in order to identify			

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	possible root causes of the fall and provide immediate interventions. An entry will be completed in the EMR (Electronic Medical Record) addressing the fall, any injuries, physician and family notification, and interventions initiated. 5. All falls will be discussed by the interdisciplinary team the next business day morning after the day of the fall to determine other possible interventions to prevent future falls...The care plan will be reviewed and updated, as necessary." 3.1-45(a)(1) 3.1-45(a)(2)			

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure each resident's drug regimen was free of unnecessary drugs in that 1 resident had no attempted dose reduction for Remeron and Zolpidem. This affected 1 of 10 residents reviewed for unnecessary medications. (Resident #113) Findings include:	F0329	F329 States that each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.Based on a comprehensive assessment of a	01/19/2013

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	Resident #113's record was reviewed on 12/17/12 at 10:25 a.m. The record indicated Resident #113 was admitted with diagnoses that included, but were not limited to, osteoporosis, difficulty speaking, insomnia, bladder dysfunction, glaucoma, difficulty swallowing, muscle weakness, cerebral artery occlusion with infarction, high blood pressure, depressive disorder, and vascular dementia. Physician's recapitulation orders dated 12/1/12 through 12/31/12 indicated an order for Mirtazapine (antidepressant) 15 milligrams (mg) by mouth every bedtime, with a start date of 12/01/11, and an order for Zolpidem (5 mg by mouth every bedtime, with a start date of 12/01/12. No dose reductions could be located in the resident's record for the Mirtazapine or the Zolpidem. During an interview on 12/17/12 at 3:00 p.m., LPN #1 indicated she could not find where there had been a reduction for the Mirtazapine or Zolpidem, and didn't know why the physician had not done one. A policy and procedure for "ASC Psychotropic Medication		resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.The facility will ensure this requirement is met through the following corrective measures:1. Resident #113 has been reviewed by the IDR team and physician notified of request. 2. All residents who utilize anti-psychotropic medications will be audited, by DNS or designee, to ensure that proper GDR's have been initiated. 3. GDR tracker (see Attachment F329-3) will be completed by Social Services Director or designee, to ensure GDR assessments are completed and GDR requests from the physician are timely. The IDT team will review the GDR tracker monthly in the Behavior meeting. Nursing and Social Services staff will be in-serviced on or before January 17th 2013, by the DNS and Staff Development Coordinator, (see Attachment A and Attachment F329-1) on the ASC Psychotropic Medication Management Program. 4. The DNS or designee will utilize the	

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	Management Program" with no date, was provided by Medical Records Employee #7 on 12/18/12 at 3:00 p.m. The policy included, but was not limited to, "Policy: It is the policy of American Senior Communities to ensure that a resident's psychotropic medication regimen helps promote the resident's highest practicable mental, physical and psychosocial well-being. These medications are managed in collaboration with the attending physician, pharmacist and facility staff to include behavioral interventions, assessment and reductions a applicable...2. The facility will initiate a request for a Gradual Dose Reduction at least on the following schedule for each drug...c. For residents who use sedative/hypnotic medications a GDR must be initiated per the following guidelines: -For as long as the resident remain on a sedative hypnotic, the facility should attempt a GDR quarterly unless clinically contraindicated by the physician. d. For resident who use antidepressant medications a GDR must be initiated per the follow (sic) guidelines:: -During the first year that the resident is admitted to the facility on an antidepressant or after the facility has initiated an antidepressant, a GDR must be attempted in two separate		Continuous Quality Improvement Unnecessary Medication tool (see Attachment F329-2) to ensure GDR's are recommended, when appropriate, weekly for 4 weeks, then monthly for 6 months, then quarterly thereafter. These audits will be reviewed during the facility's quarterly CQI meetings and the plan of action adjusted accordingly. If a threshold of 95% is not met, the plan of action will be adjusted accordingly by the CQI committee. 5. The above corrective measures will be completed on or before January 17 th , 2013.	

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	quarters with at least one month in between attempts, unless clinically contraindicated by the physician. -After the first year, a GDR must be attempted annually unless clinically contraindicated by the physician...." 3.1-48(a)(2)			